CHAPTER 3

DIVISION COMBAT HEALTH SUPPORT OPERATIONS

Section I. PLANNING COMBAT HEALTH SUPPORT FOR DIVISION OPERATIONS

3-1. Division Combat Health Support Planning

a. Division CHS operations involve all of the factors which must be considered in the initial developmental stages of the division CHS plan. For information on conducting health service support in joint operations, see Joint Publication 4-02. The CHS plan is updated to meet tactical or CHS operations requirements. The following factors should be considered:

- Mission.
- Commanders's intent.
- Planning guidance.
- Tactical plan.
- Enemy.
- Terrain.
- Troops.
- Weather.
- Threat (including medical threat).
- Operational conditions.
- Operational constraints.
- Military population supported.
- Civilian populace in the AO.
- Medical personnel status.
- Equipment status.
- Supply status including Class VIII.
- Wartime host-nation support.
- Indigenous medical services.
- Communications capability.
- Nuclear, biological, and chemical defense.
- Nuclear, biological, and chemical casualty considerations.
- Training status.
- Casualty estimates.
- Medical evacuation requirements.
- Medical evacuation capabilities.
- Corps CHS.
- Nonmedical support requirements from division (engineers, transportation).
- Division support requirements.
- Special operations requirements.
- Army airspace command and control.
- Records and reports requirements.
- Phases of operations.

- Courses of actions.
- Information requirements (maps, essential elements of friendly information, updates).
- Policy and procedure updates.

b. The division CHS plan is developed by the DMOC staff according to guidance found in FMs 8-10,8-10-6,8-10-8,8-10-9, 8-42,8-55, 100-5, 101-5, and in consultation with the division surgeon. After the CHS plan has been approved by the division commander, it is incorporated into the division CSS plan. For information on conducting health service support in joint operations, see Joint Publication 4-02.

3-2. Division Support Command Operation Plan and Operation Order

The DISCOM OPLAN and OPORD, when published, are developed by the DISCOM S2/S3 section using input from each of the staff elements of the DISCOM headquarters.

a. The chief of the DMOC is responsible for supervision and development of CHS input for the DISCOM OPORD and OPLAN. The division CHS plan serves as the base document for this input. The division CHS plan is revised or updated based on mission analysis or changes in CHS requirements. The DMOC chief is tasked by the DISCOM S2/S3 for CHS input to the DISCOM OPORD and OPLAN for support of division operations. The S2/S3 indicates time-line requirements. The DMOC chief is involved in the initial stages of the CSS planning process. In this role, he should be aware of any CHS planning requirements.

b. The chief of the DMOC tasks the medical operations branch to collect, receive, analyze, and update all information which could affect CHS operations. Information used to develop the CHS input is derived from—

- Mission analysis.
- Medical and general military intelligence and threat summaries from corps intelligence producers, corps medical brigade, and theater battlefield technical assets (see FM 8-10-8 and FM 34-54).
- Personnel estimates.
- Combat health support estimates.
- Casualty estimates (developed or obtained from S 1).
- Main support battalion and FSB status updates.
- All planning considerations that were identified in paragraph 3-1.

c. The medical operations branch develops a CHS plan based on guidance received from the DISCOM commander and DMOC chief. The DMOC provides CHS operational planning updates to the division surgeon. The CHS plan is briefed to the DISCOM commander for approval, as required. The CHS plan is provided in written format or presented orally to the DISCOM S2/S3 in a six-paragraph format of the OPLAN (FM 8-55) within the prescribed time lines identified in the oral or written tasking.

d. The DMOC has a primary responsibility for the coordination of division and corps medical assets in support of the division. Supporting medical elements should be pre-positioned according to the CHS plan and anticipated requirements. Division and corps evacuation assets should be task-organized to support the area of greatest casualty density. All supporting medical elements should be

issued the maximum allowable levels of Class VIII and other required supplies. The DMOC must establish and maintain continuous communications with division medical companies located in forward areas. The medical operations branch maintains a situation map and should use charts to monitor functional areas which may include—

- Corps ground and air ambulance assets.
- Army airspace command and control overlays.
- Status of evacuation platforms.
- Division to corps evacuation schedule.
- Division to corps evacuation delays.
- Supply status including critical Class VIII shortages.
- Critical medical personnel shortages.
- Pending resupply missions from corps.
- Critical medical equipment shortages.
- Medical maintenance backlog.
- Patient status board (for example, awaiting evacuation).
- Hospitals supporting the division.
- Blood status.

Section II. CONDUCTING COMBAT HEALTH SUPPORT FOR COMBAT AND MILITARY OPERATIONS OTHER THAN WAR

3-3. Combat Health Support for Division Offensive Operations

a. The objective of an offensive operation is to destroy or bring under control the forces of areas critical to the enemy's overall defensive organization. This is accomplished before the enemy can react. The four general forms of offensive operations are—

- Movement to contact.
- Attack.
- Pursuit.
- Exploitation.

Offensive operations are characterized by aggressive initiative on the part of the commander. The commander initiates rapid shifts in the main effort to take advantage of opportunities. He maintains the momentum and launches the deepest and most rapid destruction of enemy defenses possible. Although these operations are roughly sequential, any offensive operation can change. It has the potential to develop into either a more rapidly progressing operation or a defense. The entire series can proceed by step from movement to contact to an eventual pursuit; however, an attack can quickly shift forward or backward as enemy resistance varies.

b. Basic considerations which influence the use of medical units in supporting combat operations are—

- The commander's plan (his concept of the overall operations).
- The anticipated patient load.
- The expected area of casualty density.
- The expected combat environment (conventional, NBC, smoke and obscurants).
- Mission, enemy, terrain, troops, and time available (METT-T).
- All CHS planning factors identified earlier in this chapter.

c. The following are essential characteristics of CHS in offensive operations:

(1) As areas of casualty density move forward, the routes of evacuation lengthen, requiring forward displacement of MTFs and evacuation assets, thereby extending evacuation lines to supporting facilities.

(2) Heaviest patient loads occur during disruption of the enemy's main defensive position, at terrain or tactical barriers, and during assaults on final objectives.

(3) Unit-level medical elements may be required to furnish temporary emergency medical support to indigenous or displaced persons. They perform this humanitarian act if time and resources permit. The extent of this support is decided by the tactical commander; however, assistance is normally confined to emergency medical treatment and advance trauma management.

(4) The major casualty area of the division will be the zone of the main attack. As the attack accomplishes the primary division task, it receives the first priority in the allocation of combat power and related combat support and CSS. The division commander's allocation of forces indicates roughly the areas which are likely to have the greatest division CHS requirements.

(5) The greatest medical challenge for the tactical commander is the movement of casualties from point of injury to casualty collecting points to facilitate evacuation to MTFs. This process will become increasingly more difficult as the battle area extends.

d. Coordination is the key to successful implementation of division CHS. Coordination must continue as various forms of the offensive operation are initiated. When the tactical situation or unexpected events force changes to the CHS plan, the DMOC staff aggressively coordinates those changes as expeditiously as possible. The DMOC staff monitors the effects of division CHS to identify flexible responses which will enhance CHS operations. Coordination with all medical elements in the division area, as required (FSB, MSB, supporting corps medical elements, and supported units), must be continuous. The DMOC staff is involved in coordinating the following CHS requirements in support of offensive operations:

(1) *Treatment elements.*

- Augmentation or reconstitution.
- Personnel and equipment replacement.
- Emergency resupply of Class VIII.
- Relocating medical elements.
- Preventive medicine measures.
- Combat stress control.

- Coordinating corps CHS augmentation in support of the division.
- Combat health support augmentation using division medical assets.
- Enemy prisoners of war casualty management.

(2) *Evacuation elements.*

- Locating patient collecting points and AXPs.
- Establishing ambulance shuttle systems.
- Updating the medical evacuation plan, as required, with the corps MRO.
- Monitoring road clearances for corps evacuation vehicles.
- Using nonmedical evacuation platforms.
- Monitoring mass casualty management procedures.
- Refueling and resupplying corps evacuation assets.
- Replacing personnel, equipment, and vehicles.
- Coordinating A2C2 plans.
- Monitoring large area obscurant use for air ambulance A2C2 planning.
- Monitoring NBC casualties.

3-4. Combat Health Support for Division Defensive Operations

a. Division CHS is influenced by the same basic considerations discussed previously in connection with offensive operations. Patient load reflects lower casualty rates, but forward area acquisition of patients is complicated by enemy actions and initial direction of maneuver to the rear during a mobile defense. Combat health support personnel are permitted much less time to reach patients, complete necessary emergency treatment, and remove them from the battle site. Increased casualties among medical personnel further reduces the medical treatment and evacuation capabilities in forward areas.

b. The heaviest patient work load, including those produced by enemy artillery and NBC weapons, may be expected during initial enemy attacks and in counterattacks. The enemy attack may disrupt communications and delay both air and ground evacuation of patients.

c. Because reserve combat forces play a decisive role in defense, location of MTFs must not complicate or interfere with their choice of maneuver. A CHS plan for maneuver reserve forces must be prepared for implementation on short notice. Medical elements identified to support this plan should be used to assist other medical units while awaiting deployment with the reserve force.

d. The depth and dispersion of the mobile defense creates significant time and distance problems inpatient evacuation support to security forces. Security forces may be forced to withdraw while simultaneously carrying their patients to the rear. The use of air ambulances expedites the evacuation of these patients, but requires detailed A2C2 coordination and is dependent on the tactical situation.

e. The probability of initial enemy penetration and the need to reduce support area clutter requires locating medical treatment elements farther to the rear than in the offense.

f. The nature of the defending force's missions and employment requires modification of normal division-level CHS methods. Medical companies are located to the rear of brigade and division AO. During static situations, initial commitment of division ambulances in support of aid stations is minimal. Lengthy, unsecured ground routes may permit patient evacuation only at periodic intervals. In many cases, the MSRs are all but shut down in the brigade area to prevent the enemy maneuver force from exploiting them as high speed avenues of approach into the division rear. This is done to channel the enemy force into engagement areas but it has the negative affect of limiting the ground ambulances' ability to evacuate casualties from the forward areas. The MSMC may need to maintain a high degree of mobility to support areas of high casualty density as the battle develops. The DMOC must maintain a current status of the FSMCs and of the tactical situation. Threat information pertaining to evacuation routes, both air and ground, must be disseminated to all medical evacuation assets.

g. Medical units must be repositioned prior to the defense. This is done to ensure that they can continue to treat and evacuate without having to move. This should be planned to ensure a continuum of care even if the defense becomes a retrograde.

3-5. Retrograde Operations

a. A retrograde operation is a maneuver to the rear or away from the enemy. It is part of a larger form of maneuver to regain the initiative. Its purpose is to improve the current situation or prevent a worse situation from occurring. The objectives of a retrograde operation are to—

- Gain time.
- Preserve forces.
- Avoid combat under undesirable conditions.
- Maneuver the enemy into an unfavorable position.

Retrograde operations may facilitate repositioning forces, shortening lines of communications (LOCs), or permitting unit withdrawal for employment elsewhere. Commanders can use retrograde operations to harass, exhaust, resist, delay, or damage an enemy. Success in retrograde operations requires strong leadership, exemplary organization, and disciplined execution. Because of their effects on other units, retrograde operations require the prior approval of the next higher command. As do other operations, retrograde operations rely on logistics support. Logistics planners advise commanders and operational planners on the status, capabilities, and limitations of the logistics support for retrograde operations. Logistics and CHS planners assist in formulating courses of action, adjusting support operations to conform to the commander's decisions. Logistics unit commanders and staff officers play a key role in assisting and preparing the force for retrograde operations.

b. The three forms of retrograde operations are delays, withdrawals, and retirements. In delays, units yield ground to gain time while retaining flexibility and freedom of action to inflict maximum damage on the enemy. Withdrawing units, whether all or part of a committed force, voluntarily disengage from the enemy to preserve the force or release it for a new mission. In each type of a retrograde, a force not in contact with the enemy moves to the rear—normally by a tactical road march. Commanders direct the retrograde OPLAN and coordinate complementary operations to enhance the probability of success.

c. Combat health support in retrograde movements may vary widely depending upon the operation, the enemy reaction, and the situation. Firm rules that apply equally to all types of retrograde operations are difficult to establish, but certain factors must be considered in CHS planning for retrograde operations.

(1) The effects of time on evacuation and treatment and the number of patients cleared from any battlefield are dependent upon the time and means available. In stable situations and in the advance, time is important only as it affects the physical well-being of the injured. In retrograde operations, time is more important. As available time decreases, the DMOC, the brigade surgeon, and the division surgeon must evaluate the capability to collect, treat, and evacuate all patients.

(2) Evacuation routes are required for the movement of troops and materiel, causing patient evacuation in retrograde movements to be more difficult than in any other type of operations. Command, control, and communications may be disrupted by the enemy. The measures taken to counteract factors impeding evacuation during retrograde movements are beyond the scope of medical authority. For successful evacuation, planning for such events, in conjunction with the appropriate medical authority, should be included in tactical standing operating procedures (TSOPs). Mobility of division medical companies is enhanced by evacuating patients directly from the battalion aid station (BAS) to corps hospitals. However, this technique should only be used when the tactical situation requires rapid relocation of Echelon II MTFs.

(3) Special emphasis must be placed on the sorting (triage) of patients, and consideration must be given to the type of transportation available for evacuation. Seriously wounded patients should be evacuated by the fastest means available. Proper sorting and rapid evacuation of patients lessen the work load on MTFs. This should be a coordinated effort between air and ground modes of patient evacuation.

(4) During a retrograde operations, CHS elements usually displace by echelon and hold patients for the shortest possible time. Locations for successive positions from forward to rear areas must be planned in advance. Since the general direction of movement is toward the location of existing medical elements, initial locations may be placed farther to the rear than in other types of operations. For continuity of support, the next rearward location is occupied by an MTF prepared to function before the forward facility is closed or displaced.

(5) Frequency of displacement is determined by the rate of movement, the distance involved, and the tactical situation. Medical units must be displaced before there is danger of involvement in the action of forces conducting the retrograde operations. Displacement can be made by echeloning within units or by moving complete units.

(6) Future operations to be undertaken at the conclusion of the retrograde operations must be considered when planning CHS. This consideration is most important in maintaining a continuum of care.

(7) When the retrograde operation involves a rearward passage of lines, detailed advance planning between surgeons of the units concerned is required. Prior planning for casualty collecting points, AXPs established with corps evacuation assets and treatment elements, and Class VIII resupply must be accomplished. In retrograde operations, mobility of all CHS elements must be maintained. This permits their rapid movement without the need to abandon patients. The CHS planner can assist in maintaining this mobility by keeping the aid station free of patient accumulation, keeping the clearing station patient load low by coordinating evacuation with supporting medical elements, and by recognizing increases in patient loads early. These principles hold true to units

conducting a passage of lines internally in a division. The CHS plan for support of both divisions during the passage of lines stipulates that the passing division transports its own patients to the rear. Critically sick or injured patients may be transferred to the division in place to expedite their treatment. This technique is employed to preserve the mobility of CHS in the division which is to assume the covering force or defensive role. For definitive information on retrograde operations, see FM 100-5.

3-6. Military Operations Other Than War

a. In addition to war, there are many other Army missions which are prolonged. Military operations other than war (MOOTW) occur during peacetime and conflict. Conflict is characterized by hostilities short of war to secure strategic objectives. The National Command Authorities may commit US Army units to the full range MOOTW including—

- Nation assistance.
- Security assistance.
- Humanitarian assistance and disaster relief.
- Support to counter drug operations.
- Peace enforcement operations.
- Peacekeeping operations.
- Arms control.
- Combatting terrorism.
- Show of force.
- Attacks and raids.
- Noncombatant evacuation operations.
- Support for insurgences and counterinsurgencies.
- Domestic support operations.

b. In MOOTW, the provisions of CHS and health education play a more direct role in countering both the medical and general threat. Combat health support in the full range of MOOTW can be defined as those actions encompassing all military health-related activities taken or programs established to further US national goals, objectives, and missions. For definitive information of CHS in the operations identified above, see FM 8-42.

3-7. Mass Casualty Operations

Procedures for mass casualty operations should be contained in the TSOP of each unit. Tactical standing operating procedures for mass casualty operations are coordinated through the principal staff, approved by the command, and coordinated with subordinate and higher commands. If mass casualty operations are viewed as part of area damage control (ADC) missions, then the medical requirements will be integrated into the overall plan.

3-8. Integrated Battlefield

a. Health planning factors on the integrated battlefield include—

- Increased casualties.
- Supply and resupply disruption.
- Contamination of unit equipment, supplies, and personnel.

- Compromised medical evacuation.
- Mission performance degradation due to individual protective postures.
- Prolonged treatment procedures due to decontamination.
- Disruption of LOCs.
- Equipment damage (high altitude electromagnetic pulse).
- Targeting of specific areas.
- The need to adjust CHS to meet the complexities generated.

b. The integrated battlefield will present mass casualty situations which will develop quickly and have long-lasting residual effects. The range of weapons, NBC weapons/agents, directed-energy weapons, and weapon delivery systems will cause high casualty rates, especially in poorly trained and improperly equipped troops and units. Echelon III and Echelon IV MTFs may well be target areas; this will compromise hospital services.

c. The flexibility of the proposed hospitals and their component construction allows reconstitution of other hospital units or the ability to task-organize to meet the medical needs of the combat zone.

d. The requirement for patient selection/sorting (return to duty [RTD] and nonreturn to duty [NRTD]) is of extreme importance. Many of the patients, particularly those with mild symptoms or combat stress, have excellent RTD potential. These individuals, if promptly and properly treated, may RTD in hours to days and significantly influence the outcome of the battle. It is important not to over evacuate soldiers with minimal or no exposure to NBC hazards to hospitals. Putting these soldiers in hospitals could verify for them that there is really something wrong other than simple fatigue and stress. It could influence their thinking and cause them to exaggerate the severity of their conditions. Putting these soldiers in hospitals could slow their recovery and possibly result in their developing a chronic disability.

e. Those potential RTD patients with chemical effects or radiation exposure requiring hospitalization will be evacuated to CSHs. Combat stress casualties will be evacuated to the appropriate combat stress unit.